Prior Authorization Form
General PA Form

INSTRUCTIONS FOR COMPLETING THIS FORM

Please fill out all sections on all pages completely and legibly. If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Use one form per member, per drug, please. This form, along with other PA forms can be found at: **https://welcome.optumrx.com/tenncare/landing.**

Drug and drug class specific PA forms must be used whenever available. Specific PA forms are linked below. For the most up-to-date list, please visit the website above.

- Acute Opioid PA Form (pdf)
- Anti-Anxiety PA Form (pdf)
- Antihyperkinesis: Stimulants PA Form (pdf)
- Antidepressant SNRI PA Form (pdf)
- Atypical Antipsychotic PA Form (pdf)
- Beta Agonist Combos PA Form (pdf)
- Buprenorphine Products PA Form (pdf)
- CFTR Potentiator PA Form (pdf)
- Chronic Opioid PA Form (pdf)
- Compound PA Form (pdf)
- Diabetic Supply PA Form (pdf)
- Epclusa PA Form (pdf)
- General PA Form (pdf)
- GLP-1 Agonists PA Form (pdf)
- Growth Hormone PA Form (pdf)
- Harvoni PA Form (pdf)
- High Potency Statin PA Form (pdf)
- IDD Worksheet PA Form (pdf)
- Influenza Antiviral PA Form (pdf)
- Journavx PA Form (pdf)
- Mavyret PA Form (pdf)
- Narcolepsy Agents PA Form (pdf)
- Opioid Exceptions PA Form (pdf)
- OTC Agent PA Form (pdf)
- PCSK9 Inhibitors PA Form (pdf)
- PPI PA Form (pdf)
- Promethazine PA Form (pdf)
- Sovaldi PA Form (pdf)
- Topical Immunomodulator PA Form (pdf)
- Weight Management Agents PA Form (pdf)
- Viekira PA Form (pdf)
- Vosevi PA Form (pdf)

MEMBER INFORMATION

Member Last Name: _____
Member First Name: _____
Member ID: _____
Date of Birth (MM/DD/YYYY): _____ Sex: ☐ Male ☐ Female
Street Address: _____
City: _____ State: _____ ZIP: _____
Phone Number: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____
Prescriber First Name: _____
Prescriber NPI: _____ Prescriber DEA: _____
Specialty: _____ Office Phone: _____ Office Fax: _____
Supervising Physician and DEA (if applicable): _____
Office Street Address: _____
City: _____ State: _____ ZIP: _____
Is the prescriber a single patient contract holder for this patient? ☐ Yes ☐ No
Is the prescriber a TennCare provider with a TN Medicaid ID? ☐ Yes ☐ No

Member Last Name: _____ DOB: _____

MEDICATION AND DISPENSING INFORMATION

Non-preferred drugs may require trial and failure, contraindication, or intolerance of a preferred product.
Please refer to the **Preferred Drug List** for Preferred and Non-Preferred Drugs. Please refer to the **Clinical Criteria, Step Therapy, and Quantity Limits for TennCare Preferred Drug List (PDL)** for drug-specific PA criteria and quantity limits.

With the exception of the "**Branded Drugs to be Classified as Generics List**," TennCare is a mandatory generic program in accordance with state law (TCA 53-10-205). Approval of Non-Preferred agents requires trial and failure, contraindication, or intolerance of two (2) preferred agents, unless otherwise indicated on the **PDL**.

Drug Name: _____ Drug strength: _____
Drug Formulation: _____ Dosing Frequency: _____
Quantity: _____ Day Supply: _____
If available, can the generic equivalent be used? ☐ Yes ☐ No
Is this a compounded product? ☐ Yes ☐ No

CLINICAL CRITERIA

1. What is the diagnosis for the requested drug? (Specify and list ICD-10 code: _____
2. Has the patient failed an adequate trial of a preferred drug? ☐ Yes (if yes, please document below) ☐ No
    a. Drug _____
        i. Strength: _____
        ii. Length of Trial: _____
        iii. Reason for discontinuation: _____
    b. Drug _____
        i. Strength: _____
        ii. Length of Trial: _____
        iii. Reason for discontinuation: _____
3. Has the patient experienced an adverse event or had an intolerance to a preferred drug? ☐ Yes (if yes, please document below) ☐ No
    a. Drug _____
        i. Strength: _____
        ii. Length of Trial: _____
        iii. Reason for discontinuation: _____
    b. Drug _____
        i. Strength: _____
        ii. Length of Trial: _____
        iii. Reason for discontinuation: _____
    c. Is the patient currently taking the requested drug? ☐ Yes ☐ No
        i. If yes, how has the medication been supplied? _____
4. Please include any other information pertinent to the PA request: _____

PRESCRIBER SIGNATURE

By signature, the prescriber confirms the above information is accurate and verifiable by patient records.

Member Last Name: _____ DOB: _____

Prescriber Signature: _____ Date: _____

INSTRUCTIONS FOR SUBMISSION

PA requests can be submitted to Optum Rx via fax (866-434-5523), by phone (866-434-5524), or by electronic PA request, such as CoverMyMeds. For questions, please call 1-866-434-5524. Optum Rx will provide a response within 24 hours upon receipt.